OLIVE BRANCH COUNSELING, LLC

Kelli Hauer-Skorman and Associates
9100 Conroy Windermere Road, Windermere, FL 34786
407-612-5808 www.olivebranchcounselingorlando.co

Confidential Client Intake Form

Name: _____ Age: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Transgender: ☐ M to F ☐ F to M

Home Address: _____

Mailing Address (if different than Home): _____

Email Address: _____ May we email you? ☐ Yes ☐ No

Best Contact Phone Number: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

SOCIOCULTURAL BACKGROUND:

Racial/Ethnic Background:

☐ White/Caucasian
☐ African-American
☐ Asian-American Asian or Pacific Islander
☐ Black African
☐ American/Hispanic
☐ Latino/Latin
☐ Native American Alaskan
☐ Arab/Middle Eastern
☐ Arab/Middle Eastern-American
☐ Hispanic-American

Multiracial Other Specify: _____

How much do you identify with your ethnic heritage?

☐ Not at all ☐ A little ☐ Somewhat ☐ Moderately ☐ Strongly

Do you identify yourself in other ways that are meaningful to you (e.g., cultural background, sexual orientation, class status, physical ability)?

If yes, please list: _____

Religious preference: _____

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Please share anything important about any cultural or spiritual beliefs that you may feel important for your therapist to know.

_____

_____

_____

Are you currently active in your religion? ☐ Yes ☐ Somewhat ☐ No

Would you like to incorporate your religious/spiritual values and/or rituals into the counseling process? ☐ Yes ☐ No ☐ I Don't Know

ACEDEMIC/WORK BACKGROUND:

Place of employment: _____

Position: _____

Hours worked per week: _____ Years with company: _____

Are you satisfied with your job? ☐ Yes ☐ No

Highest Educational degree: _____

Major: _____

Are you a student? ☐ Yes ☐ No

If yes, where are you studying? _____

RELATIONSHIP/SUPPORT HISTORY:

Current relationship status: ☐ Single ☐ Committed Relationship ☐ Married

☐ Living with Partner ☐ Separated ☐ Divorced ☐ Widowed

How many significant romantic relationships have you had? _____

Are you satisfied with your current relationship? ☐ Yes ☐ No ☐ I don't know

Do you feel supported by your partner? ☐ Yes ☐ No ☐ I don't know

How would you rate the quality of friendships?

☐ Very Poor ☐ Unsatisfactory ☐ About Average ☐ Excellent

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How many people can you count on for emotional support? _____

FAMILY BACKGROUD:
Please list the members of your family living with you, their genders, ages and occupations

Family Member	Occupation	Age

Your Family's Spiritual/Religious background: _____

How much conflict do you experience with Family?

☐ None ■ Very Little ■ Some ☐ Moderate ☐ Strong

Who are you closest to in your family? _____

Describe your Mother: _____

_____

Describe your Father: _____

_____

PHYSICAL HEALTH:

How is your Physical Health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Last Health Examination? _____

Please list current Physical symptoms or health concerns: _____

_____

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Do you have a disability? ☐ Yes ■ No

If yes, please specify: _____

Are you currently taking medication? ☐ Yes ☐ No

Please list all medications: _____

Name of Primary Care Physician: _____

Are you having trouble with sleep habits? ☐ Yes ☐ No

Are you having difficulty with appetite or eating habits? ☐ Yes ☐ No

Have you had a significant weight change in past two months? ☐ Yes ☐ No

Do you have any problems or worries about sexual functioning? ☐ Yes ☐ No

How many times a week do you exercise? _____

MENTAL HEALTH HISTORY:

Have you ever been a victim of: ☐ Emotional abuse as a child ☐ Physical abuse as a child ☐ Sexual molestation/abuse as a child ☐ Emotional abuse partner/spouse ☐ Physical abuse by a partner/spouse ☐ Sexual abuse by a partner/spouse

Other Trauma: _____

Have you ever received counseling before today? ☐ Yes ☐ No

If yes, where? _____ When?_____ Duration: _____

Was the counseling beneficial? ☐ Yes ☐ No

Additional comments? _____

Are you currently seeing a Psychiatrist? ☐ Yes ☐ No

Were you ever prescribed psychiatric Medications? ☐ Yes ☐ No

If yes, what was prescribed? _____

Are you currently having suicidal thoughts?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

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Have you had suicidal thoughts in the past?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

If so, when? _____

Are you having thoughts of harming others?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you had thoughts of harming others in the past?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you intentionally inflicted harm upon yourself?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

If so, when? _____

Have you ever attempted suicide? ☐ Yes ☐ No If yes, date(s):_____

Have you or your family members have ever had psychological issues? ☐ Yes ■ No

If yes, please describe: _____

_____

_____

Alcohol and Drug Usage (if applicable):

	Past/Current	Frequency	Treatment
Alcohol:	_____	_____	_____
Cigarettes:	_____	_____	_____
Marijuana:	_____	_____	_____
Illegal Substances:	_____	_____	_____
Prescription Drugs:	_____	_____	_____

Have you ever been treated for an eating disorder? ☐ Yes ☐ No

Treatment Provider _____ Date: _____

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How would you rate the intensity of the problem or concern that brought you in?

☐ 1 (minimal) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 (extreme)

How have you attempted to cope with your issue? _____

_____

_____

How many sessions do you think you'll need?

☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10-12 ☐ 13 or more

Why are you seeking counseling? *Please explain what you would like help with or the issue(s) you want help addressing.*

_____

_____

_____

_____

When do you believe the issues began? _____

Please provide any additional information you may find beneficial for the therapist to know about you.

_____

_____

_____

_____

Printed Client Name: _____

Signature: _____ **Date:** _____

Typing your name replaces your manual signature.